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ABSTRACT

Four papers presented at an all-day workshop at Ohio State University focus on stimulating the physical development of mentally retarded children. Noted in the introduction is importance of cooperation between university training programs and facilities serving the mentally handicapped. Julian Stein discusses the physical and motor development of the mentally retarded and lists principles of effective programs such as promoting a better self image and developing emotional stability. Considered by Gladys Hillsman is stimulating physical development in children at home, the dangers of labeling, and the possibility of professionals are actually contributing to the problems of the retarded. The role of the school in stimulating the physical development of the mentally retarded child is discussed by Tom Edson who examines program aspects such as variety of approach, differing attention spans, noncompetitive experiences, the value of routine, and the justification of equipment. In the final paper Judith Curry focuses on the role of the residential institution and suggests innovative programs such as temporary-care programs to relieve parents of the handicapped, the use of volunteers, and of prison inmates to work with the retarded. References are provided for each paper as is a listing of papers available in the mental retardation training program technical report series. (MC)

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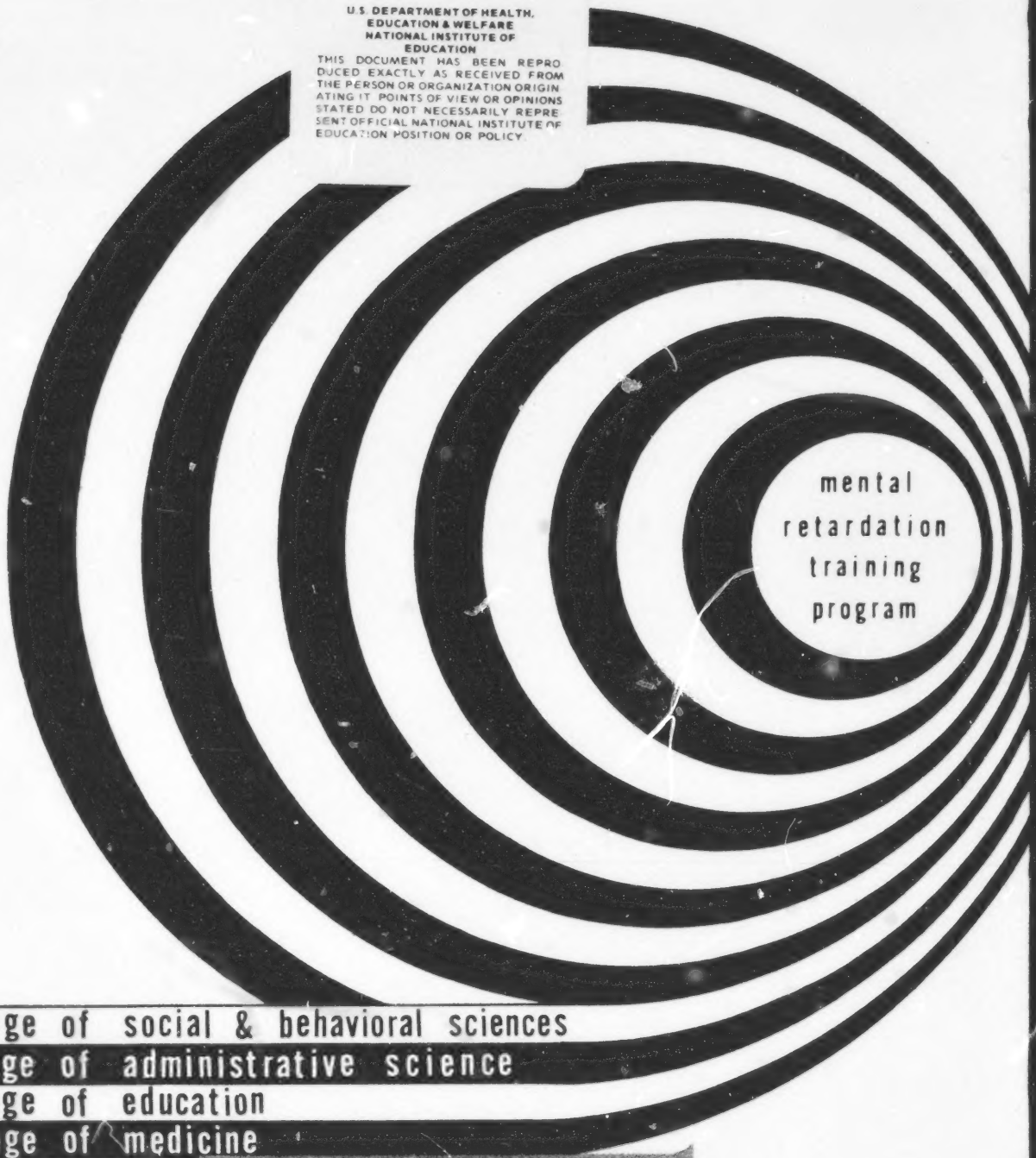

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STIMULATING PHYSICAL DEVELOPMENT OF MENTALLY RETARDED CHILDREN

70-3

the ohio state university

The Mental Retardation Training Program, a joint project of the College of Administrative Science, College of Social & Behavioral Sciences, College of Education, and College of Medicine, is committed to the alleviation of the manpower shortage in the field of mental retardation. To this end, it provides an interdisciplinary arena for research and training through the mechanism of service to the retarded.

HISTORY

The impetus for the Training Program began with the Report of the President's Panel on Mental Retardation in 1962, and culminated in the enactment by the 88th. Congress of a series of three pieces of legislation to stimulate research, training and service facilities for mental retardation. In 1965, the report of the Citizen's Committee to the Governor of Ohio specifically stressed the need for manpower training in University-Affiliated Facilities for the Mentally Retarded.

GOALS

The broad objectives of the Training Program are:

- to develop an interdisciplinary approach to mental retardation research;
- to provide interdisciplinary instruction in mental retardation;
- to disseminate information related to mental retardation;
- to develop and promote methods of prevention of mental retardation;
- to expand scientific knowledge in the diagnosis and treatment of the retarded;
- to extend the breadth and depth of both student involvement in the community and in-service instruction for professionals.

ORGANIZATION

To serve its complex objectives, the Training Program has a Policy Council consisting of the Deans of the participating Colleges; a Program Advisory Committee consisting of faculty representatives of many generic disciplines; a Liaison Advisory Committee consisting of representatives of state and community agencies; an administrative triad (listed below); and three Program Coordinators through whom the academic departments relate in order to achieve the stated program objectives.

Address inquiries to:

Mental Retardation Training Program
9 W. Buttles Avenue
Columbus, Ohio 43215

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THE OHIO STATE UNIVERSITY

MENTAL RETARDATION TRAINING PROGRAM

Technical Report Series

70-3

Papers Presented at an All-Day Workshop

Friday, June 19, 1970

STIMULATING PHYSICAL DEVELOPMENT OF MENTALLY RETARDED CHILDREN

Jointly Sponsored By

The Ohio State University
Mental Retardation Training Program

Ohio Division of Mental Retardation
Columbus State Institute

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Technical Report Series
of
The Ohio State University
Mental Retardation Training Program

The OSU Mental Retardation Training Program is an all-University program devoted to instruction, service, and research in problems of mental retardation and other developmental handicaps. Among full time and cooperating staff in the Center are representatives from the following disciplines:

Business Administration
Dentistry
Education
Home Economics
Medicine
Nursing
Nutrition
Occupational Therapy
Physical Therapy
Physical Education
Psychology
Social Work
Sociology
Speech
Vocational Rehabilitation

The technical report series serves as a mechanism through which the ideas and activities of participating specialists and their students can be disseminated to the larger professional community. Theoretical treatises, operational design concepts, as well as reports of service and research activities are included in the series.

Papers may subsequently be submitted for publication in scholarly journals. For this reason, no quotations from the reports should be made without the written permission of the author(s). Critical reaction to the papers, where appropriate and with permission, will be made available to our readers.

Inquiries regarding additional copies of this report should be addressed to:

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INTRODUCTION

Joseph J. Parnicky, Ph.D.*

When a new service appears within a community there are inevitable questions as to how it will fit into the existing constellation. How will it effect the lifespan or lifestyle of the oldtimers in the area? This has certainly been the case on a score of campuses throughout the nation with the recent establishment of University Affiliated Centers for the training of practitioners for the fields of mental retardation and related developmental handicaps. Those of us who have joined the Center at Ohio State University acknowledge the basis for such questioning and accept the responsibility for responding.

The role of the Center must be developed in no less than two major settings -- the University itself and the

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Community at large. On the campuses, the emergence of these centers is both a response to society's needs and the faculty's recognition that university structures need remodeling periodically if they are to be related to current times. Traditions allege that deans of colleges have perpetuated feudal kingdoms within university walls. While such depiction is weighed by mythology, it is certainly true that the Federal legislation which created UAC's specified new contractual relationships among colleges that has already resulted in an historic impact on higher education. But how this is being realized is not of primary concern to us today.

This workshop is concrete testimony of the OSU Center's attunement to the importance of finding and fulfilling significant, pertinent roles within the community that we reside. Resolute in this purpose, we have embarked on a series of discussions with representative services in the community serving mentally retarded individuals, their families and their neighborhoods. Today's workshop is the outgrowth of one continuing dialogue. Less than a year ago, Dr. William Gibson, the Director of the OSU Center and Dr. Donald Lucas, then the Superintendent of Columbus State Institute, formalized the discussion by establishing a liaison committee consisting of three members from the

Institute and three from the Center.* From the first, our meetings have been concerned with initiating ways in which our respective missions of service and training, and our respective resources of institution and university should be joined in mutual projects.

How does a workshop focused on "Stimulating Physical Development of Mentally Retarded Children" fit into this schema? It represents a joint effort to meet a need which is vital to both campuses. At the Institute, the staff recognizes lacks in the program available to residents. At the Center, the staff is conscious of the importance that students be more alert to the topic. Feelers into the professional community indicated that practitioners in the area were likewise looking for new information and approaches to stimulating growth and development of retarded children. Moreover, the concern was not within a single segment or a single discipline, but permeates a broad cross section of the services and practitioners. While limited, samplings among parents confirm that parallel concerns and interests exist there, too.

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The registration for today's sessions confirms the preliminary impressions of the planning group. The members of the liaison committee see this as an introductory step in a progression of activities that will bring OSU students of various disciplines into the wards, classrooms and offices of the Institute and facilitate the exchange among and communication between the staffs of both institutions.

As an example of other concurrent activities. discussions with the Franklin County Mental Retardation Board have resulted in joint establishment of two classes -- one for evaluation purposes and another for demonstration of training techniques -- at our temporary quarters on Buttles Avenue. Discussions between the Center and the Division of Mental Retardation, the Columbus Board of Education, the State Rehabilitation Commission, and others are comparably seeking to determine ways in which community, university and center resources can be blended into more effective means for the amelioration, and possible prevention, of mental retardation. Within two years, we shall be installed in a new four-story building located in the University Hospital portion of the campus. Today we have personnel to offer training in an interdisciplinary medium for practitioners enrolled in eleven professional schools. In the new facility, it will be possible to more than double this range

of disciplines. We are also negotiating to provide "new career" training within the local "model cities" area as well as extension training for those already holding degrees and employed in the field. These are but some of the reasons why we will welcome suggestions for additional partnerships that may be generated by this day's and future deliberations toward fulfilling the training mission of the Mental Retardation Center at Ohio State University.

THE PHYSICAL AND MOTOR DEVELOPMENT OF THE MENTALLY RETARDED

Julian U. Stein*

Since time immemorial man has extolled the virtues of an active, vigorous life that promotes a sound mind in a sound body. Plato in 380 B.C. said:

> Lack of activity destroys the good condition of every human being, while movement and methodical exercise save it and preserve it.

The great -- and the not so great -- thinkers, philosophers, and educators have long associated the inter-dependence of body functions. Separation into convenient physical, mental, social, and emotional compartments is simply an academic exercise -- any coach, business man, or hypochondriac with ulcers, psychosomatic, or somatic psychological problems will vouch for this! Good physical development has long been associated with a good life and with successful

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intellectual performance. Comenius stated this in 1650:

> Intellectual progress is conditioned at every step by bodily vigor. To attain the best results, physical exercise must accompany and condition mental training.

In 1860, Herbert Spencer put it succinctly:

> We do not yet sufficiently realize the truth that as, in this life of ours, the physical underlies the mental, the mental must not be developed at the expense of the physical...

And, in 1917, Herbert S. Jennings stated:

> The young child perhaps learns more and develops better through its play than through any other form of activity.

Play is the work of childhood! Even Spock and Gessel -- and most parents -- recognize the importance and fundamental truth that muscle is there before nerve and nerve is there before mind. The many motor milestones that we use as criteria to ascertain the development of our children reflect the high priority given to physical development and motor function. However, until recently, little thought or concern was given to the physical development, motor function, and fitness of the mentally retarded. We were so concerned with making the educable mentally retarded academically acceptable that we completely overlooked and neglected his most basic of needs. Conditions for the trainable retarded weren't much better -- old wives' tales, preconceived ideas of what the retarded could and could not do, lack of expectation, satisfaction with mediocrity, and broad, sweeping

generalizations abounded. Individuals were not looked upon as individuals but rather as items off an assembly line where performances were based on CA, MA, and IQ: labeling and categorization on the basis of IQ alone were especially prevalent.

The retarded were kept in classes working at the very things with which they had the most difficulty -- ' readin', writin', and 'rithmetic. The harder we tried to "larn 'em thar academics", the more we contributed to their muscular atrophy, and the more this condition adversely affected their total function. So many trainable retarded spent their days sitting, inactive, passive, gaining weight, and becoming the more unfit in every way. Certainly, in residential facilities understaffing and over-population contributed to these conditions. However, we can allow these situations to become our alibies, rationalizations, and justifications for permitting the retarded to regress and have greater motor deprivation. A concern related to motor deprivation is associated with the growing number of early childhood education programs in which little emphasis is given to play and physical activity. Since motor programs are being used for remedial purposes then logically they should be an important part of preventive programs at earlier ages. Could it be that children who participate in early childhood

education programs with little concern given play and physical activity will be worse later than had they not had such an opportunity? Only time will tell.

Then researchers began to wonder about the relationship of physical ability and function to total performance in general and to intellectual performance in particular of the mentally retarded. Consistently studies showed that there was a higher correlation between these measures in the retarded than in the non-retarded population, the retarded did poorer than their non-retarded contemporaries, and the retarded scored at levels considerably below the norms for their age, sex, height, and weight.

But, like the bumblebee which doesn't know -- or wouldn't believe -- the scientific evidence that proves he can't fly, many persons working daily with the retarded at the grass roots level did not hear about these results. So, they developed programs that were aimed at the specific needs and at the functional levels of their students. Activities were taught in a systematic, progressive manner emphasizing the concrete rather than the abstract. The sequence was such that the retarded could move in a more logical, slower, and more sequential order in moving from one step to the next. Much consideration was given to seeing that each individual was motivated and that, regardless of his age or level, all

experienced success, satisfaction, and had fun. The reports -- both experimental and empirical -- from these dedicated teachers gave a far different picture!

In almost all cases there was no more correlation between motor performance and intellectual performance than within the range of normal IQ's. The educable mentally retarded performed at levels that were commensurate with their age peers and in some cases they were among the top performers of their classes. When various national programs were used as criteria -- AAHPER's Youth Fitness Test, AAU Physical Fitness Test Battery, and the President's Council on Physical Fitness Test Program -- many retarded youngsters attained the same levels and achieved the same awards as their non-retarded contemporaries. In virtually all cases, the retarded had greater amounts of progress than their classmates. In short, this newer group of studies showed that when given the opportunity to participate in a well-planned, carefully administered, progressive, and regular physcial education programs the retarded were as capable as their non-retarded peers. Of course, as would be expected there was a great deal of variability in their performance and much over-lap with the performances of the non-retarded.

While not too much has been done in the way of formal research with the trainable retarded, trends show far more

progress and achievement than expected or anticipated. Reports and case studies provide many thrilling success stories, promising practices, exciting and productive results:

-- A tumbling team from Partlow State Hospital (Alabama) received a standing ovation from over 6,000 people at the completion of the performance at a gala which was part of a recent clinic of the President's Council on Fitness and Sports. These trainable youngsters were great; they did things on mats which I had never seen performed there.

-- A trainable young man from Iowa had the highest set and game among 5,000 bowlers from 41 states and Overseas Dependent Schools in Germany in a Mail-A-Graphic Bowling Tournament. How many of you have bowled a 544 set? Or a 222 game?

-- In the Special Olympics held in Chicago in 1968, almost fifty percent of all first, second, and third place winners scored better than the seventy-fifth percentile in the 50-yard dash, standing broad jump, and softball throw; almost eighty percent scored above the fiftieth percentile. These comparisons are based on the regular national norms of the Youth Fitness Test -- these are the same norms used in the Presidential Fitness Award program!

Many less dramatic but equally important stories can be related. Retarded youngsters of all ages and with degrees of intellectual deficit have attained high levels of proficiency and performance in art, music, swimming, and other non-academic areas. It is long past time that each of us evaluates how we have contributed to the failures of the retarded -- are they really their failures or ours because of our inability to reach and teach them? While all of us like to say what we have done for the retarded, in all honesty, do we have to too often ask what have we done to them?

Threads and trends emerging from nutritional studies and research have implications for our areas of concern.

-- When nutritional therapy was given a group of children with Down's Syndrome significant progress was noted in certain physical and motor characteristics; no changes were evident in cognitive function. The control group did not show any progress in motor and physical performance.

-- The brain develops and matures in three readily identifiable sequences -- during the first which occurs during the pre-natal period, brain cells increase in number; during the second which occurs during the first year to eighteen months of the immediate post-natal period, brain cells continue to

> increase in number and in size; and during the third which occurs after a year to eighteen months after birth, brain cells increase in size. Nutritional deprivation during the first or second periods results in irreversible effects upon the brain. However, nutritional deprivation d ing the third stage is amenable to therapeutic approaches involving enriched diets and appropriate nutriments. Whether or not the permanent effects are differential on various sections of the brain needs thorough investigation.

Many factors contributed to inconsistencies among the old and the new studies reporting physical performance and motor function of the mentally retarded.

Many retarded youngsters were thrust into these studies never having participated in the activities nor experienced many of the more fundamental skills. In addition, most of these retardates never had the opportunity to participate in physical education or recreation programs to learn the skills and movements that most of us learned by just being one of the kids on the block. Further, the test items themselves often meant little or nothing to the retarded. It is not uncommon to hear them ask during such sessions, "Why should I?" Many of the items that must be understood -- as

many as possible, farther, higher, faster, more -- for successful performance have little or no meaning to the retarded. Lack of motivation is possibly the greatest deterrent to good performance. So many times the results that we interpret as indices of physical or motor performance are, in truth, reflections of many other factors and characteristics.

Further clouding the situation is the fact that many investigators have used interchangeably such terms as motor proficiency, motor ability, motor fitness, motor efficiency, physical efficiency, and even physical fitness, without clearly defining and delimiting their meanings. Consequently, there is a group of studies that purport to measure the same characteristics but actually measure quite different characteristics. Conversely, there are studies which appear to be concerned with different traits which are, in fact, dealing with the same qualities. Because of divergent training, experiences, and philosophies of professional personnel from heterogeneous disciplines who deal with the retarded, it is most important that mutual understanding be developed of certain terms which describe physical and motor development. A pressing need of utmost importance which should receive high priority is the development of a taxonomy of terms and definitions which will be functional and mutually acceptable to all groups interested and involved in physical activity and recreation programs for the retarded and handicapped.

There is no distinct separation between physical fitness and motor function. However, minimum levels of specific components of physical fitness, such as strength, power, agility, flexibility, endurance, balance, speed, and general coordination are instrumental in the attainment and satisfactory performance of a variety of motor skills and movement patterns. It could be that lack of an adequate base in terms of minimum levels of physical fitness has caused the consistently low results of retarded subjects on tests of motor ability. In other words, without minimizing the importance of educating through the physcial, we must not overlook or neglect education of the physical as a necessary first step, especially with younger and lower functioning retardates.

Recent emphasis upon the role of coordination, agility, balance, and other motor functions upon the development of certain complex intellectual functions and academic skills furthers the cause and need for utmost concern over this phase of the program for the retarded. Studies have consistently shown that the structure and function of motor development of the retarded followed the same patterns and trends as those of the non-retarded, although at somewhat lower levels. This suggests even further that the inability of the retarded to perform at levels commensurate with their contemporaries is a function of factors other than lack of ability per se.

That there is apparently no single factor of motor ability further complicates the picture. Little relationship or correlation has been found between gross and fine motor skills. In fact, these relationships are not great between measures of different gross movements; even lower relationships are found among different fine motor skills. Only when respective muscle groups and specific muscles are used in identical manners in performing motor activities has there been any significant relationship between these skills. It could be that our instruments have not been sufficiently refined to detect minute differences. Quite possible function and relationship between nervous and muscular systems, nerve cell and muscle tissue, are just as specific and defined for gross as fine movements. In fact, basic factors such as strength and endurance are being shown to be specific as applied to movements which go through the same degree and range of movement.

Motor function is quite individual in nature, as different individuals will show quite different patterns -- high in one area, low in another, while another will show the reverse. Many factors interplay and affect one's performance so that we can often question just what we have after administering motor tests. For example, a young boy had just received a diagnosis of terrible, horrible, lousy

gross and fine motor ability on a complete pediatric neurological examination. After the ordeal, the boy was holding a toy in one hand and a full glass of water in the other. He dropped the toy and finding no place to put the glass proceeded to do a one-leg squat, picked up the toy, and returned to a stand without spilling a drop of water. The neurologist threw up his hands and asked, "Just what do these tests measure and mean?"

For a number of years educators have been engrossed in research attempting to ascertain the rightful role of motor activities in the education of the human organism. Although findings and conclusions drawn by researchers in the area have not completely substantiated the fact, enough seems to have been uncovered to point toward the widely accepted idea that motor ability is closely related to the more finely developed neurological phenomenon which controls memory, perception, and problem-solving.

In keeping with the concept of the unit of the individual, it seems unreasonable to leave the neuromuscular out of the learning situation. It is evident that the functioning of the total organism is affected when any one of the components -- physical, social, emotional, or intellectual -- is slow to develop. Individual capacities for learning and doing depend upon the total growth of child, of which motor development

is an important and integral part. Improving motor achievement brings about more controlled movement, thereby helping a child to handle a very important part of his environment. The more success encountered in bodily movement, the more likely a child to become self-contained, confident, independent, secure, and dignified. When such confidence is established, the improved mental picture that a child has of himself seems to bring about better success in other areas.

The motor base is the foundation from which the individual's body scheme (the knowledge of the construction and spatial relationship of the different parts of the body such as fingers, arms, and legs), and finally, the self-concept or ego-consciousness evolve. So often in programing for the retarded we have overlooked and neglected these simple truths -- we have put the cart before the horse and in so doing have greatly restricted the potential and development of the retarded.

Without minimizing the contributions to physical development and motor function, a wide variety of values can come from physical activity and recreation programs approached developmentally on the basis of individual needs:

1. Help participants get out of the failure-frustration rut so many have experienced in activities throughout their lives. These activities cannot be new

and additional experiences in failure or they will turn away from them. The breadth of physical education and recreation activities is so great that everyone, regardless of age, experience, background, ability, or lack of ability, can find something in which he can succeed and achieve.

2. Encourage the participant to see a task through from beginning to end as he establishes realistic, functional, meaningful, and practical goals for which he works and follow-through to attain.
3. Help participants to take pride in participating, achieving, doing, and in the results of his efforts.
4. Promote a better self-image, greater self-esteem, more self-respect, and improved self-confidence.
5. Promote more self-discipline and self-control.
6. Make participants more cooperative -- and, more competitive, especially for improving and doing a better job himself. We must not overlook the stages through which competition progresses -- self improvement gradually moving through increasing degrees of competition against others and finally to the sophisticated aspects of team and group activities. Competition stages closely relate to the stages of play -- individual, parallel, and team or group.

7. Become more socially aware and conscious.
8. Develop greater emotional stability and control.
9. Improve physical fitness, motor performance, physical proficiency, and motor ability.
10. Be able to use leisure and uncommitted time constructively and wisely.
11. Develop readiness for more complex activities in all areas of endeavor including the intellectual.
12. Prepare for general or specific vocational activities; use as vocational readiness program or preparation.
13. Learn to live and play by the rules.
14. Have fun -- this cannot be underestimated as an important motivator and stimulator. We must capitalize on the nature of children, their characteristics, and all that is being provided by specialists in child growth and development. Despite more knowledge and information about growth and development are we guilty of applying and using less? What has happened to childhood?

Positive effects are not going to just happen by putting children in these programs. We must structure activities, approaches, methods, and procedures to attain the desired objectives. In many cases, more repetition is needed; in

other situations smaller "bites of the apple" are needed. Different activities can be used to accomplish the same end -- these are still means to ends and not ends in themselves. The same activity can be used to achieve different objectives. In all honesty, we must admit that there is no Utopia or Shangrila -- no single program or approach will be everything to everybody -- this belies the fact that kids are different and as such must be approached as individuals. No longer can we overlook or neglect the fact that we too -- the teachers and leaders -- are individuals, which will influence greatly our approaches to meeting the needs of our charges.

In planning activities specifically designed for developing motor function, the following should be considered:

1. Attention must be given to mobility training that promotes the earliest stages of neurological organization. Selected coordination activities are important in aiding this kind of development.
2. Balance activities of a variety of types need to be a regular part of the program designed to enhance motor development.
3. Attention must be given to improving basic motor functions -- walking, running, stair climbing, hopping, skipping, jumping, climbing, throwing,

catching, dodging, and so on. These basic movements can be incorporated into games and relays.

4. Movement exploration can be used to improve both motor ability and physical fitness.
5. Phythmic activities and dance are effective ways to improve motor ability.
6. Motor skills are improved through gymnastic activities -- tumbling, apparatus, dual and group stunts, balancing stunts, trampolining.
7. Several types of recreational and sports activities provide opportunities to apply and improve motor skills -- swimming, ice skating, roller skating, bicycling.
8. Effective use can be made of both small and large apparatus.

The retarded need to have more opportunities in physical education and in recreation programs where vigorous physical activity plays a prominent role. We need to put first things first and to build a sound foundation before moving to the next step. More emphasis must be placed upon these phases of the program which in addition to the physical makes important contributions to the total growth and development of the retarded. Participation in these programs can stimulate, motivate, and contribute to the total learning of the

retarded. I submit to you that just as the motor preceeds the mental, physical education and recreation can and should be the core around which the total school and educational program of the retarded should be built, especially the younger and lower levels. Activities basic to physical education and recreation are such that they can reach the retarded, can trigger them to action and to levels of achievement not here-to-for thought possible for them. This medium is concrete, significant, and meaningful.

The retarded only ask for opportunity -- opportunity to spread their wings, to experiment, and to build their own rockets to the moon so that they might say: "Give me pride, give me substance, give me a life of my own and I'll stop feeding off yours."

Let each of us recall and be guided by Aristotle's profound, but simple, observation: "If one should look at things as they grow from the beginning, it would be the best method of study."

STIMULATING PHYSICAL DEVELOPMENT IN CHILDREN AT HOME

Gladys M. Hillsman, R.N.*

Before we can talk about stimulating development in children who have mental retardation, we need to look first to our attitudes, feelings and labels. Maybe William James' essay, "On a Certain Blindness in Human Beings" should be required reading. He wrote:

> Our judgments concerning the worth of things, big or little, depend on the feelings the things arouse in us. Where we judge a thing to be precious in consequence of the idea we frame of it, this is only because the idea is itself associated already with a feeling....

Now the blindness in human beings is the blindness with which we are all afflicted in regard to the feelings of creatures and people different from ourselves.

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What are our mental images and feelings when we say, "retardate", the "retarded", the "C.P.", etc? What are the images and feelings when we talk about children? What are we really doing when we depersonalize people by referring to them by their most profound symptom? Mental retardation is a symptom, cerebral palsy is a symptom, paraplegia is a symptom. What are we really doing? This is the most gross type of depersonalizing and stereotyping. In the name of humanity there are no such entities as a "retardate", a "C.P.", a "diabetic", etc. Today let's look at kids -- a kid is still a kid, no matter what symptoms he has.

Can we consider the concept of deviance by Kai T. Erickson? He writes:

> Deviance is not a property inherent in certain forms of behavior; it is a property conferred upon these forms by the audience which directly or indirectly witness them. Sociologically, then, the critical variable in the study of deviance is the social audience rather then the individual person, since it is the audience which eventually decides whether or not any given action or actions will become a visible case of deviation.

He further states:

> The norm retains its validity only if it is regularly used as a basis for judgment.... In our culture these norms are almost irreversible.

How often do we lose the kid because we are hung on the label? If we are to make any degree of progress, we

must face what we are doing to people with our labeling procedure. Does the term "retardate" or the term "the retarded" convey any specific useful information? Does it help us see a particular person who has a certain degree of retardation, who functions at varing levels on a range of abilities? Does it help us in working with a certain person? Does the label help the person who was stuck with it? Have you ever had a teenager or young adult who had retardation ask you, "What is a 'retardate'?" Care to squirm on that one?

What happens to the child at home will hinge on the attitudes, feelings, beliefs etc. conveyed by the professional who made the diagnosis and explained the findings to the parents. Was the emphasis on the fact that this is a kid who will do the usual kid things? So he has tantrums -- that's being a kid! Normal behavior can become overwhelming when the parents have been given a problem-oriented diagnosis. Do the parents think of him as "sick" -- is he treated then as a sick child? We talk about parents being "over-protective" -- how much of this do we set up by what we convey?

A baby who is seen as being "sick" too often is "propped", "padded" and held -- what I call "increase retardation techniques". The baby needs to be on a firm surface -- the floor is a great place to be. On his back

or throughly propped, the baby is like a helpless bug -- he has no chance to develop head balance, strengthen his arms and shoulders, practice rolling over, etc. Placed on his tummy on the floor, he can practice these things. What does a child see on the floor? What is his visual stimulation? Get down on the floor and see the world from an infant's point of view, or a toddlers -- it's an education. (I can still hear a very little on a crowded elevator at at Christmas time saying, "Mommy, there's only legs down here.") One ingenious parent had taken a piece of plywood and put four legs on it; set it inside the playpen, leaving an eight inch guard rail and raised the baby closer to a mother's smile-level. The empty space beneath was used for storage of diapers and other baby equipment. This gives the young child another level of vision.

What attracts the infant or beginning toddler as he is free to excerise on the floor? Where do his eyes focus? What will motivate him to move when the time comes? He needs to be encouraged to "reach out" to new experiences. He needs the chance to get dirty, "get into things", climb, etc. Many children fall, break bones or require stitches. Think about this: We frequently accuse parents of being "overprotective", but if a kid is allowed to roam and then gets lost, breaks a bone, or gets a cut, professional

sentiment too often is, "surely you realize he needs more supervision than the average child." What hypocrites we are at times. This is when the parents especially need support and encouragement to continue to help their child reach out.

Before we can be critical of what parents do or do not (from our point of view) to help their children, we need to learn what a day is like in that home. What is the total family situation -- not just the concerns around the child who has symptoms of brain dysfunction? The reverse is also true -- we need to encourage more parents to be active in observing and participating in the programs conducted for their children, both private programs and those that are publically supported. There still is far too much of the attitude, "If we get rid of the parent, we can manage the kid."

Parents need considerable support and encouragement when the child is slow to respond. It's terribly hard to "talk to" and play with a non-responsive infant or young child. In addition, it's very depressing to the parents. As one mother said, "What professionals forget is that every day when I get out of bed I have to face it all over again, and frankly some days I can't face it." Surely, we have all felt the same way at times -- with a lesser burden to face.

In the stimulation process, we cannot forget that too often we encourage the parents to provide an atmosphere of telling the child "what to do, where to do, with whom to do". Having conditioned the child to grow up without the opportunity to make choices -- turning him into a robot, we then write books that state: "people with retardation are incapable of making judgments, they tend to be passive, etc." What nonsence, when we don't know how these people would respond if we changed what we do.

There are many areas and specific techniques that could be discussed. Basically, we need to remember that the child needs to have the opportunity to learn through exploration. He needs to learn to respond to verbal commands (which means that he needs the same rules in the same places for the same reasons as other children -- to do otherwise puts him in an artificial world and emphasizes to him "you are different.") He needs to be treated as much like other children as is possible. This also means that we must get rid of the "happiness syndrome". To say that a child must always be happy is to deny him his humanity. To be human means that one has a gamut of emotions and feelings.

Finally, we must look at the rules and regulations within the "systems" which inhibit the physical stimulation of children. Many youngsters live close enough to programs

and schools so that they could walk to school, but regulations say they must be transported. We increase the child's handicaps so that when he grows up he has not learned to ride on public transportation, to walk to places and thus cannot get involved in some of the leisure time activities which are scheduled.

If I make only one point today, let it be this: that we look to our beliefs, attitudes, biases, etc. and see whether or not we are contributing to the problems of those with whom we work.

I like this paragraph from Frederick Whitehouse.

> A profession should make us more human, not less so; more alive, not less so; more dedicated, not less so and we default on our professional birthright unless we reach out to others and communicate this feeling of concern for the common bond between us all.

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THE ROLE OF SCHOOL IN STIMULATING PHYSICAL DEVELOPMENT OF THE MENTALLY RETARDED CHILD

Tom A. Edson*

The objectives of the physical education program for mentally retarded (I detest the word "retarded", that this child takes a longer period of time to learn what the normal child would learn, whatever the "normal" child might be. I feel that we all are retarded in some areas) are to provide happiness, enjoyment and pleasure for each boy and girl, and an opportunity to develop self-confidence and self-reliance by experiencing success. In a physical education program, I feel that the child's attitude and values are just as important as the skills he is learning. I think we should try to replace and reduce the fear and stress of

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trying something new with positive values and attitudes. We can do this by positive reinforcement (giving ribbons or T-shirts). The program should be noncompetitive since many of these children have suffered too much frustration and failure. Each boy and girl may learn without embarrassment or fear of making mistakes. Our program should be one of accepting each boy's and girl's liabilities and assets and taking this into consideration. The teacher, if conscientious, must prepare to meet the individual needs -- this takes time, equipment and individual planning. We hope through physical education that each boy and girl will gain a better feeling of self-worth, where each experiences success. We hope to improve his personal adjustments of acceptance of self and others along with the development of proper attitudes. I think that we, as physical education instructors, can provide understanding, security, and opportunities for new experiences and recognition as we would for any boy or girl.

We need teachers that realize the children might be "a little slow learning in one area", "a little sensitive to change" -- it's not either "none" or "all", but a matter of degree of "sometimes", "usually", and "frequently". We need teachers who will integrate the slow learning child with the children in regular classrooms (for the time tolerance

level will permit), in regular physical education and "recess time", (even if the noon supervisors need a special workshop) besides having his own physical education adjusted to his individual needs. We need the type of teaching that is not"telling" or "explaining", but inspirational (the slow learning responses to involvement and demonstration. They remember better what they see than what they hear) type of teaching where the child will do the activity at home, where you know if you are walking home from school and see the child doing the activity that you taught during the day -- you know it's coming from within rather than without. I feel it is not the quantity of time, but the quality of the time the instructor spends with the student.

There are many approaches -- sequential step by step approach taking one level at a time and not moving to the next level until the child has achieved success; creative movement where child sets up his own criteria in throwing a ball against a wall or experimenting in all the different ways he can use a ball. There is a method that I feel is quite successful, which is teaching the use of equipment and the exercise program in the way that the body develops from the head to the foot. If one is going to teach jumping rope, first put the rope over head, then behind neck, back, bring up one knee with the rope under

knee, then rope back and forth over head, then step over rope with one foot and back, then jump over with two feet and back, etc.

Many children have to be exposed to a wide variety of programs and others to one program in order to break through the filament that is surrounding them. I feel we as physical education teachers cannot hand the child the "key" to open the door to find his way in life but we can structure situations realistically where maybe on a certain day, at a certain time all the factors will fall into place. Maybe the child has to find the "key" within himself. In other words, they need exposure to a variety of programs, sort of a "smorgasbord approach"!

There are three types of attention spans -- brief attention span, concentrated attention span and the selective attention span. Brief attention span in physical education for a slow learning child is one where he will walk over, pick something up, and lay it down. This one should be eliminated. The concentrated attention span is one where he picks up physical education equipment and plays with it a long time. This you want to reinforce because it might have a positive transfer to other areas. The selective attention span is one where you only want to give the child a choice of three pieces of equipment to play with (limiting his

choice so that he isn't distracted). Also, posture exercises probably will help his attention span, and therefore, improve his school achievement.

Physical education equipment such as balls, jump ropes, etc. are tools in communication -- maybe it is not the program, but the amount of individual attention and empathy provided that makes the difference in the physical education program for the special education child.

We must give the mentally retarded, "slow learning" child success in nonverbal areas while working on the verbal areas in the classroom. We must give him the motivation to come to school, thereby, giving him success in at least one area. Emphasis should be on working together, not competing with each other -- situations where they don't have to risk too much. Many of these children were first hyperactive. Then, the principal put them with a dominating type of teacher. They started to withdraw, developed an indifferent attitude and did not want to experience any more failure. Therefore, the child did not try because there wouldn't be any results and he could protect that island he calls himself. Many of these children suffer so much failure that when they do achieve well, they will try extra hard in front of their peers and "blow it". Some of these children lose their defenses when they are not around their brothers and sisters

to be measured up to. Also, many want to be "first" and the "best" because of this -- besides teaching leadership, one must emphasize fellowship as well as the foresight, and hindsight approach. Emphasis should be on the positive, the ability -- not the disability.

Many children today, not only mentally retarded, "slow learning" children, need the principle of "putting things off to a future time". One may give the example of a mother and a four year old child. The mother gives the child a penny for a piece of gum and tells the child not to put it into his mouth until he has paid the cashier. Now the child has to stand in line and wait (put off that instant gratification of putting the gum into his mouth). Well, the basketball player does the same thing when dribbling down the court. Should he take a shot or pass it to a teammate? So he puts off his gratification for the sake of the team. What better justification could one have for a physical education program for exceptional children.

I wish the fathers in the home would say, "I don't know," once in awhile instead of coming up with all the answers about sports. Many children get the impression that they must be perfect in order to play a certain sport. They do not realize that some imperfection is necessary for good mental health. Even in teaching remedial reading, the teacher should

work on the child's strengths. He might want to shoot baskets or play 4-square with him before sitting down to work on the areas that he is weak in. In other words, work on his strengths before the weaknesses. Also, many teachers will use physical education as punishment in special classes or in the primary school by having a child run around the field or to the fence and back. Yet, this might be the only area of success for a retarded child. Let's not take this area from them.

What will work for one child, will not work for another. Also, surrounding him with a great deal of equipment may make him secure. Giving him something in his hands while walking the balance beam will give him a sense of security like carrying his teddy bear. Such games as 8-square gives a child a release of energy, yet, he has to control his body within certain set limits. Games such as Russian handball, where a child builds his own skills from simple to complex, start by throwing a ball up against the wall and catching it with two hands in front of him, then to one side, etc.

Many mentally retarded children will be easy to do counseling with by keeping their hands busy with a "squeeze-E" sponge, or some other object. Physical education can be a substitute for a lack of success in the verbal areas. It

can give a fast release of energy in a short period of time. Even such things as having exercise booths in back of the classroom where a child can go and do two or three exercises with poi-poi balls or sponge balls to squeeze and then go back to his seat. The child is not wandering around the classroom, but has purposeful movement to a particular place and it will help improve his attention span. It would probably be a good idea to provide each child with one of these sponges to squeeze at his desk as a release of tension, rather than hitting his neighbor.

Many children that are classified as retarded have been moved from one place to another leaving learning gaps because of this mobility of population. What they need is a routine in the home such as meals, and especially a routine in physical education, where they are all doing the same thing at the same time -- a sense of being with the group like "choral reading". Routine serves as a "home base" -- something to come back to. I do believe in movement exploration also. Physical education might be placed in some particular areas where a child can get some sense of security and emotional stability by doing things together such as simple exercises. Many of the mentally retarded feel more secure when they know what is coming next. Peer teaching of older slow-learning children to teach younger ones

(help by the stations in an obstacle course) thus, able to review what they have learned early.

Many children, especially boys, have difficulty in handwriting. When their eyes see the number "4" on the chalkboard, the message comes in through the eyes (input), but the child cannot write it down. The reasons he cannot write might be the fact that the child's hands do not have enough experienced background. Also, we might be setting up a learning block by putting the sensory system ahead of the motor, when the motor system was there first when the child was born. How do we in physical education correct this? We can have the child work with jacks, lumni sticks; older boys -- hand grips, squeez-E's and sponge balls. This will also limber up his hands for coloring, cutting, and pasting. Put a rubber band around the pencil so his hand won't slip all the way down.

Let's talk about laterality or awareness of both sides of the body. Many of the children need to do exercises from the side to the front -- side lunge to front lunge, trunk bending to side and then to the front. They appear to have weakness in movement in this area. Also, I feel that many children cannot cross the midline of their body. When they read from left to right, they stop in the middle of the page, or when they do handwriting from left to right

they stop at the midline of their body. Mimic exercises such as the windshield wiper, chopping wood (demonstration), should be used. I definitely feel that one should be able to get the body to move from left to right before the eyes can move from left to right. After all, we live in a left to right society and I do believe that children read across the page and not down the page as adults do in fixations. Also, exercises like "swinging arms" (demonstration) while keeping the eyes and head looking straight ahead will help anchor the body and cut down on the head movement in reading.

Another point that has come up more recently is the justification of equipment. Administrators want to know why one has the equipment such as the balance beam in the classroom. Can you give five good reasons why you have the balance beam in the classroom?

1. Learn to maintain balance under changing relationships.
2. Pinpoint the center of gravity in the body.
3. Improve movement from left to right.
4. Develop lateral movement by starting in the center of the beam and moving from left to right, right to left.
5. Develop better location sense where the arms and legs are by gradually bringing the head up and looking at visual target.

6. Control yourself on a limited surface.
7. To get a better self-image -- ducking under a stick to get an idea of how tall one is. By going through a hula hoop without touching the sides -- this gives an idea of how the body fits in and out of things.
8. Increase the attention span.

I would like to conclude my talk today by stating some very definite ways to work with slow learning children:

1. Direct command and direct praise approach.
2. Prompt approach in starting to work.
3. Be consistant.
4. Read non-verbal body mannerisms and facial expressions -- give cues to what is coming next.
5. Sometimes the hand on the shoulder or pat on the back is worth more than any verbal praise.
6. Older children get status from younger children depending upon them.
7. Younger children get recognition from the older children.
8. Teach the hyperactive child to "put on the brakes".
9. Use "demonstrations" and "involvement" teaching rather than words.
10. Will relax under a routine of exercises.

11. Physical exercise will release tension.
12. Better control of physical muscles might result in a better control of emotional-intellectual self.
13. Set definite limits and remain flexible within those limits.
14. Build tolerance level gradually.

Actually, there are too many points to emphasize in this brief presentation. However, I would be most happy to provide a workshop of twelve hours with your teachers spaced over a period of two days. Thank you for your consideration and attention during this time.

ROLE OF THE RESIDENTIAL INSTITUTION

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The entire system of institutional care in this country is under careful scrutiny and in a state of transition. Many workers in the field are struggling with the problem of re-examining the purposes and programs of institutions and in determining what an ideal institution should be.

The 1968 Report by the President's Committee on Mental Retardation states:

> The dilemma of how to improve the Nation's institutions for the mentally retarded is a tough and tangled one. The essence of the problem is what to do about buildings, budgets, programs and populations that have existed in neglect and decay for many years with little or no thought being given to their needs by either State officials or the public...

Lack of understanding of the problem, overcrowding, understaffing, inadequacy of fincances, and public apathy

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are among the causes of failure to provide more appropriate programs and adequate housing.

Traditionally, institutions for the retarded have been geographically isolated from the larger community. This isolation has led to increased problems in staffing, communications, sharing of community resources, and acceptance and understanding by the community. There are many individuals in the community who pass by institutions daily, unaware of what exists at that location.

Even with the numerous problems faced by institutions for the retarded, practically all of them have long waiting lists for admission. With increased community resources and public acceptance of indivuduals with handicaps, hopefully there will be a lessening need for permanent residential placements in the future. However, the lack of funds should not always be used as an excuse for the lack of programs. It is also apparent that additional financial assistance is not going to be available in the near future.

Before going further, it should be mentioned that several programs which will be described are used, not as suggested programs for all institutions, but because they are programs with which the author is familiar and programs which are demonstrating positive results. Although this paper does not focus on specific methods for stimulating

physical development, it can be stated that this factor was considered within the total objectives of each program. Any innovative programs which are felt to be beneficial should be encouraged and given a trial with continuing evaluations along the way.

When considering change in any institutional programs or services, it is important to remember that it is the people involved who have to make the change. Workers in the field of mental retardation must be willing to be change-agents. This includes not only stimulating change in others but a willingness to accept change in ourselves. Changes in public attitude are apparent in many areas: in the mandates of the people to their government, the mandates of students to the universities, in voluntary organized efforts, and in indivudual expressions of interest and concern.

Changes made within institutions and program development in the community must evolve together. Neither the community agencies nor the residential facilities can carry out the mission alone. Each agency or service should complement other available resources.

Community and residential programs should be coordinated so that the institution is only one of the services available in the continuum of comprehensive services for the retarded individual. A liaison committee from the Mental Retardation

Training Program and the Columbus State Institute is presently in operation to develop this kind of coordination of services so that there will not be overlapping and duplication of effort.

One of the major considerations of institutions, as with all agencies involved with the mentally retarded, should be the human rights of the individual residents or clients. It is in this area that much can be done at minimum cost, and many improvements can be demonstrated. Each person who has contact with a retarded person is in a position to contribute to the dignity and self-esteem of the person. Some of the ways in which these rights may be respected are through: allowances for privacy (even in ward settings, this might be accomplished through some partitioning), allowance of personal possessions, involvement of the resident in decisions affecting his welfare, praise for a job well done, the provision of a friendly and caring environment, recognition as an individual with ability and potential for growth, calling an individual by his name rather then "Hey, you" or by some condition, not talking about the person in his presence and exhibiting a warm concern for the individual's welfare.

Personnel in institutions are actually family surrogates, providing services on a daily basis in lieu of the

retardate's own family. With this role there should be a commitment to help the resident develop his physical, intellectual, and social capabilities to the fullest extent possible and, hopefully, a return to his own family and/or the community. Materials, in such colors, form, and textures to enhance sensory stimulation should be available. This might also include the painting of murals and attractive pictures on the walls. Toys and other play materials for visual-motor activities should be on hand. These do not have to be expensive playthings, but empty boxes, old kitchen equipment, jars, and other improvised materials can be used. We know that play is the work of children, and it is through play activities that a great opportunity for growth and learning takes place.

Many state institutions still offer only long-term care, or permanent placement. If, however, the institution is to become a community resource meeting the needs of all retardates, then short-term care should be offered as a service. Some institutions are providing this through what is commonly called temporary-care programs.

One such program is in effect at the W. E. Fernald State School in Massachusetts. The original purpose of this program was mainly to offer relief to families from the care of children on the waiting list. Many families are

unable to take vacations because of the handicapped child in the home, and the temporary care program was offered for this purpose. As the program expanded and became known to the community, the service was used by families for a variety of reasons including: care of the retarded child while the mother was hospitalized to deliver another baby, illness of a member of the family or a death in the family, and in other crisis situations when the family was unable to cope with the care of the child.

The families who benefitted from this service were quite pleased with the program, and many families requested a temporary placement every six months. As the program developed, the psychology department became interested and began to work with several children during their temporary stay. Using techniques of behavior modification, many children were toilet trained or taught to feed themselves during their thirty day stay. During this time, when modification of behavior was carried out, parent involvement was also maintained so that the progress made by the child would be continued upon his return into the home. The nursing staff maintained contact with the family in the home to assist with the preparation for placement and with the carry-over of the modification programs in the home.

The temporary care program does not necessarily require extra beds or personnel. In all institutions, many of the residents return home for visits during holiday periods and during the summer, and some of them attend summer camps. These are ideal times to bring in children for temporary care programs. One problem faced with this timing was that the staff usually liked to relax a little while some of the residents were on home visits. However, this was handled through the use of volunteers and scheduling staff vacations so that they did not coincide with programming needs.

The temporary care program, although increasing paper work, can be beneficial to institutions in the long run because it encourages families to keep their children in the community. In a few instances, parents did use this service in an attempt to get their child into the institution on a permanent basis. In most of these cases, however, the children were more severely handicapped and it appeared that they would require permanent placement anyway in the future. For most of the families, one or two temporary stays during the year helped them to manage at home for the rest of the time.

Some institutions are offering residential care programs to children during the pre-school age. Although we recognize that children under six years of age progress

much better in the home situation, and we encourage families to keep their young children in the community, there are still some families who are unable to cope with a retarded child in the home and many of these youngsters require other residential placements. Foster homes are difficult to find for these children, and nursing homes have not always been the most appropriate placement to meet the child's needs. Therefore, some institutions have provided programs for the pre-school-age child.

One state school has a special unit called the Nursery Building, which is inappropriately named because it houses residents from the ages of a few weeks to ten years. In this unit is a nursery area with infants and children who are severely handicapped. Originally this building was typical of institutional settings with four large ward areas. In 1966, one of the wards was partitioned, and a special behavior modification program set up for ten of the residents. In the small partitioned area, the room was furnished to provide a more home-like atmosphere with the dining area in one corner, the living area in one corner and the beds in another. The living room furniture was donated and , although somewhat worn, was more inviting than benches. Since 1966, the entire building has been partitioned into small residence areas, and each of the

150 children in that building has an individual program based on his indivudual needs. The program has proven worthwhile for the children and several of them have been placed into foster homes. There were problems in this program with personnel attitudes and morale in other buildings which were greatly under-staffed, because the program operations in this unit required a greater number of staff and attracted a larger number of the new employees.

Specially funded programs. such as the Hospital Improvement Program, have proven to be beneficial to resident needs and should be continued and expanded. Some other successful, low-cost programs have been the Student Work Experience and Training (SWEAT) and the Volunteers in Service to America (VISTA). These programs have encouraged and stimulated young people and students to work in the field of mental retardation. The Foster Grandparents programs have been very worthwhile in providing on -to-one relationships for residents and giving the senior citizens some constructive and fulfilling activities. Every effort should be made to encourage volunteers to work with the retarded, especially on a one-to-one basis.

Another of the newest and most exciting programs was also initiated at the Fernald School. This program involved a two-way rehabilitation effort between the state school and

one of the state prison institutions. One of the purposes of the program was to assist with the manpower shortage, however, the rehabilitation effort was also extremely important. Before the program began, there was much planning, coordination and the development of guidelines and criteria between the two agencies. Applicants from the prison's minimal security area were screened carefully. A large percentage of the men in minimal security volunteered for the program. After the selected men were accepted by the Committee for this work, they were given an orientation to the School and went through the In-Service Training Program required for all new employees. Their assignment was one of the so-called "back wards" which housed adult, severely handicapped males. Each prison volunteer began a close relationship with one or two of the residents -- taking them on walks, planning recreational activities for them and assisting in training programs in the areas of self-help. The men began working five days a week and then volunteered for weekends.

This program has only been in effect for several years, but the present results have been positive. Another state school has begun a similar program, the residents appear to be making much progress, and the staff morale has improved greatly. The most positive result has been the number of

prison inmates who have gone to work in service agencies upon their parole. Many of them remained at the state school as employees and others went into community programs in the low socio-economic neighborhoods.

Needless to say, there were many doubts about such a program. One concern was the question of runaways. This was not given too much consideration by the committee because the prisoners could have escaped at the prison. In reality, there were only a few runaways out of over one hundred volunteers. Another problem, not caused by the volunteers, was one created by other personnel who thought they were being helpful by bringing such things as alcoholic beverages to the volunteers.

One of the greatest areas from which institutions could receive much assistance and support have been neglected for a long time, and this is from the parents of retarded children. Many people still view residential care for the retarded as existing primarily for the separation of retarded individuals from the rest of society. As a result, many parents faced with placement of their child develop feelings of frustration, guilt and abandonment with little support from other individuals or agencies. There are undoubtedly various reasons why many parents give up contact with their children, but it seems that in many instances continued contact has been discouraged.

The integrity of the individual's family should be preserved and a close relationship between the family, the resident and the staff should be encouraged. Pediatric hospitals are beginning to realize that children respond best and make faster progress when family contact is maintained. This has led to a relaxation of visiting hours.

If a resident is in a school setting or similar program, then parents should be encouraged not to visit or to take the individual out of the program when it interferes with his training. But parents of the more severely handicapped children, who require more constant care, could be encouraged to visit thier child often and to participate in the care of the child. Parents could assist in bathing, feeding, dressing, and even in training areas.

Through an established close relationship with the institution, its strengths and weaknesses, the parents can then assume a role in public relations for the institution. They can be of valuable assistance in informing and changing attitudes of the general public, the community and in attempting to get additional finances from legislators.

In closing, it seems appropriate to quote from the third report of the President's Committee on Mental Retardation which states:

> In the community of the future there should be no such thing as a separate population of

mentally retarded people for whom there are special group programs. The total integration of the retarded into normal community living, working and service patterns is a long-range objective. But now is the time to begin working toward it by creating the channels through which both the regular and special services needed by the retarded can be given in a unified group of public and private programs working to help all handicapped people realize their potential.

The welfare of the mentally retarded should be the concern of all Americans. Their hope for the future is in our hands.

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